APPENDIX A

QUESTIONNAIRE

TOBACCO SMOKE RETENTION PROJECT

Name_____ Race_____ Marital Status (S M W D)

Address_____ Sex_____

Age_____ Occupation_____ Date_____

Height (in.)_____ Weight_____

1. Do you smoke? Yes___ No___

2. Have you ever smoked? Yes___ No___

If yes, what type, quantity and duration of smoking?_____

_____

_____

3. Do you now have a respiratory illness? (Cold, bronchitis, flu, virus, etc.) Yes___ No___

4. Have you recently had a respiratory illness? Yes___ No___

5. Do you have any of the following diseases or symptoms?

	Yes	No		Yes	No
Influenza	___	___	Heart Disease	___	___
Pneumonia	___	___	Cough	___	___
Sinusitis	___	___	Expectoration	___	___
Asthma	___	___	Wheezing	___	___
Turberculosis	___	___	Shortness of Breath	___	___
Other Respiratory Disease_____			Chest Pain	___	___

_____

Explain yes answers: